

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after being signed by the physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use at the burial or transit parlor. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18, show any injury, or other traumatic event, the medical examiner must be advised of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 2318960				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			7 6 83 11:08 AM								
William BYRON, Bradshaw														
3. SEX male			4 RACE white			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 87					
7a BIRTHPLACE COUNTRY MD.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER					
10 CITY OR TOWN OF DEATH CAMBRIDGE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSP.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CUSTODIAN			12b. KIND OF BUSINESS OR INDUSTRY SCHOOL					
13a. STATE MD.			13b. COUNTY DORCHESTER			13c. CITY OR TOWN GOLDEN HILL			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS STAR ROUTE-CHURCH CREEK 21622		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BRADSHAW			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZA PAUL											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 224-28-7835			17. INFORMANT A ELOISE BRADSHAW			ADDRESS STAR RT. BOX 632 CHURCH CREEK MD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a)								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			(b) CONGESTIVE HEART FAILURE											
			(c) ATHEROSCLEROSIS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____								
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 19 82</u> to <u>JULY 6 1983</u> , that (we) last saw the deceased alive on <u>JULY 6 1983</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did) (did not) view the body after death.														
22b. SIGNATURE <u>Michael A. Moskowicz</u>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 7/6/83								
22e. ADDRESS <u>503 BYRN ST. CAMBRIDGE MD.</u>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7/8/1983			23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHNS CHURCHYARD			23d. LOCATION CITY OR TOWN GOLDEN HILL COUNTY DOR. STATE MD.					
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE JUL 12 1983 John J. Connelly								
BP _____														
DHMH - 16 SOM 1/B1 (VRA 15, 4)														

RECEIVED
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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

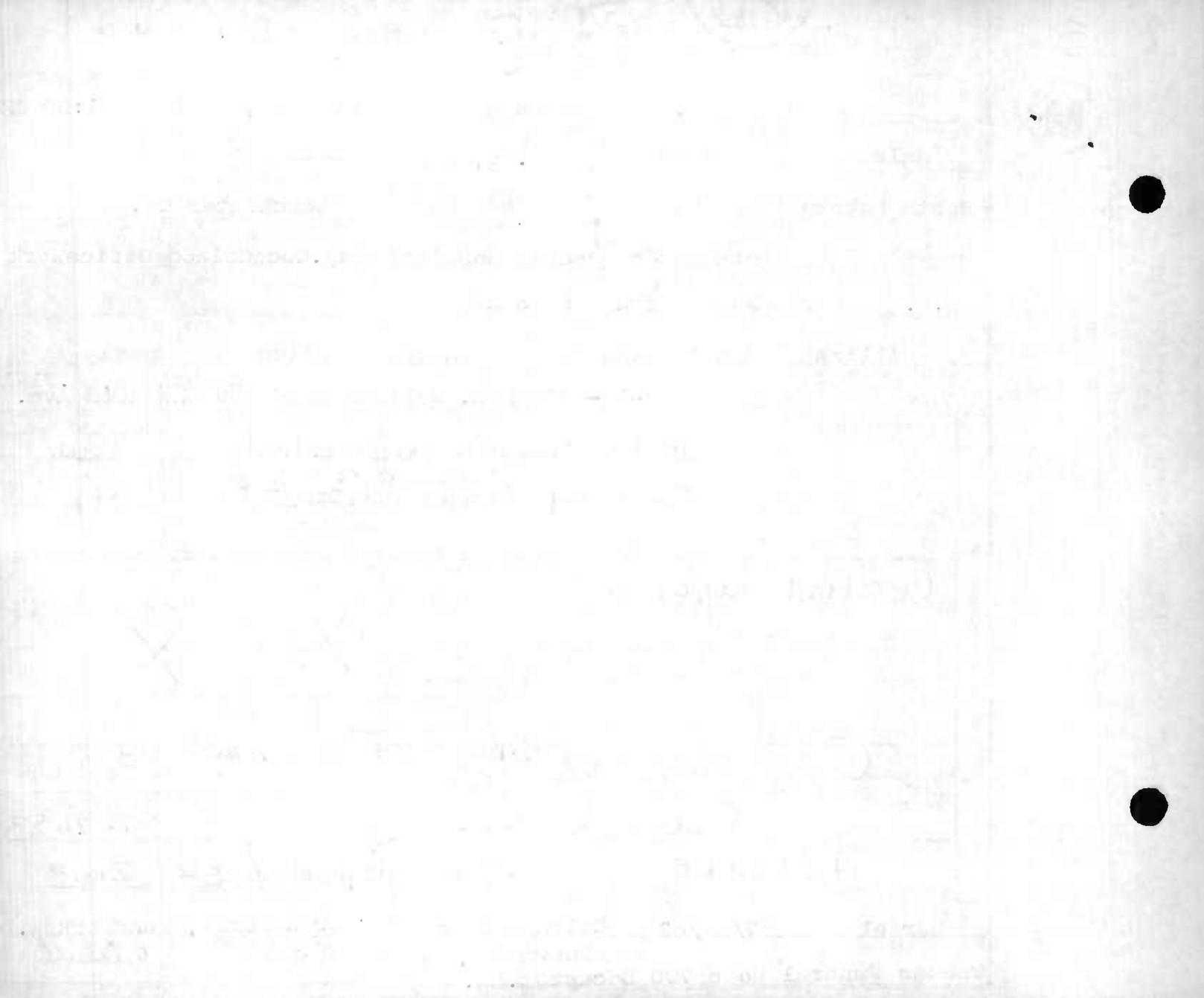
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be ppointed at one time.

Item 6, Film#G582 - 8/17/83 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										18961					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR			
John			W.	Brunning		July 20, 1983						1:00 PM			
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White		Month Day Year Aug. 25, 1926		-26-			56	YRS	MONTHS	DAYS	HOURS	MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
North Dakota			US		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					Dorchester Co. MD					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Cambridge			Dorchester General Hospital		Emp. CocaCola Cd		Office Work								
13a STATE			13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS					
N.D.			GrandForks		Grand Forks					99999					
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME												
FIRST William			MIDDLE August		LAST Brunning		FIRST Mary			MIDDLE Ellen		LAST Hogan			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS								
Yes			WW II		502-12-0446		Mrs. Wallace Reed 400 Shepherd Ave. Cambridge Md. 21161								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute massive myocardial</i> <i>4100</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost { b. <i>Coronary</i> <i>heart disease</i> / E. DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 47					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cerebral hypoxia</i>															
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>7.12.1983</i> to <i>7.20.1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.										22c. DATE SIGNED <i>7-21-83</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
<i>A.R. Winke</i>			<i>Dee</i>		<i>MD</i>			<i>40 Maryland Ave - 21613</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY	STATE			
Burial			7/23/83		Calvary Cemetery			GrandForks, GrandForks N.D.							
24. FUNERAL DIRECTOR NAME			ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Thomas Funeral Home 700 Locust St. Md.			Cambridge,		1983			John G. Cahill							

BP
DHMH - 16 60M 1/75
(VRA 15(4))

999999

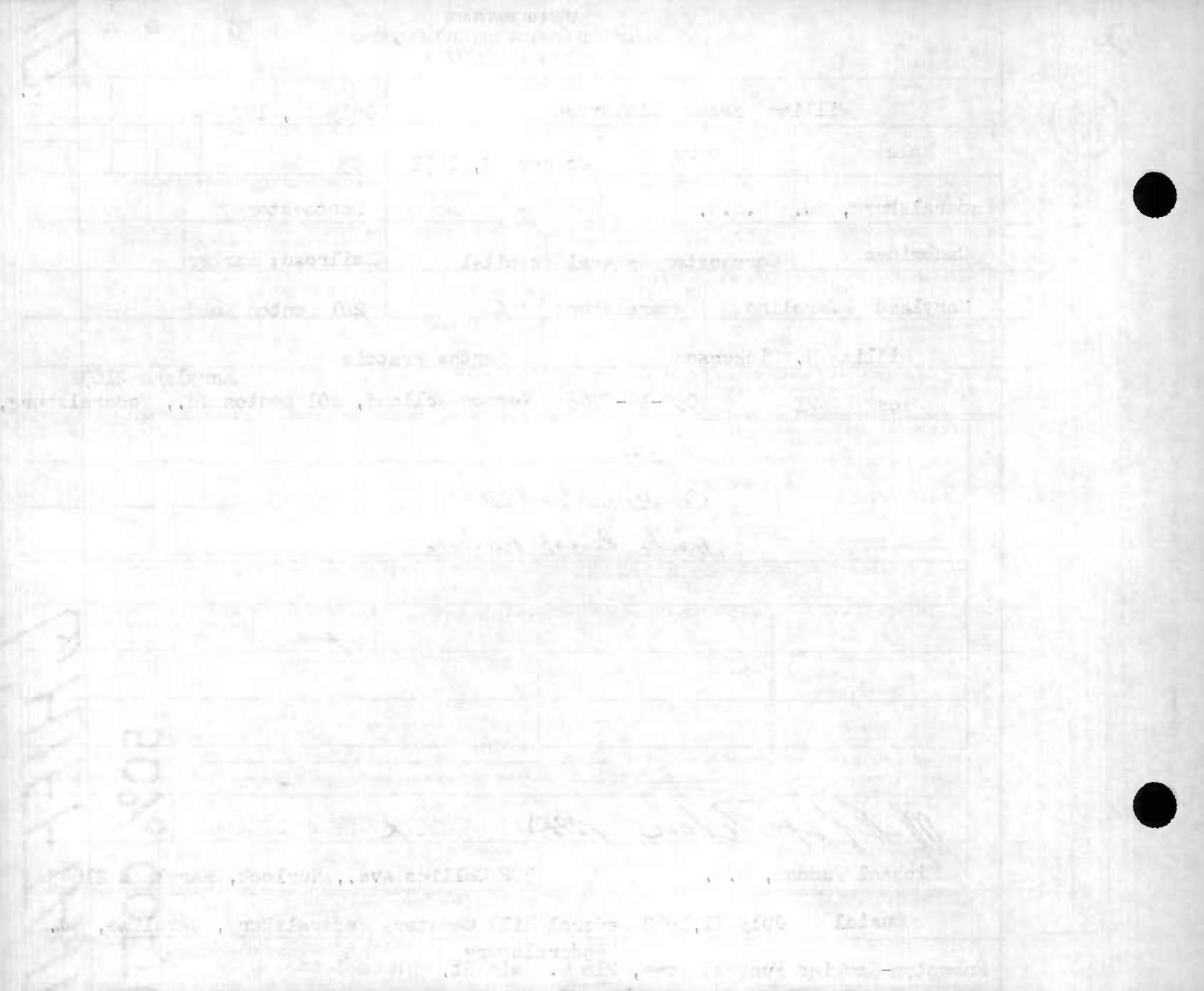


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IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 23 · 18962				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR P.M.				
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			July 17, 1983										
William Frank Dickerson																
3. SEX Male			4. RACE Negro			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Federalsburg, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			January 4, 1891			93 YRS.			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.													
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Railroad; Barber			12b. KIND OF BUSINESS OR INDUSTRY 21632	
13a. STATE Maryland			13b. COUNTY Caroline			13c. CITY OR TOWN Federalsburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 201 Denton Road				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
William H. Dickerson			Bertha Prattis													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWI 056-16-0765			17. INFORMANT Vernon Holland, 201 Denton Rd., Federalsburg,			ADDRESS Maryland 21632							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 5849 IMMEDIATE CAUSE (a) Sepsis			DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Endocarditis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c) Acute Renal Failure													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Michael Fadden, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Fadden, M.D.			22e. ADDRESS 302 Collins Ave., Hurlock, Maryland 21643													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 21, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Federal Hill Cemetery			23d. LOCATION CITY OR TOWN Federalsburg, Caroline, Md.							
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home			ADDRESS 216 N. Main St.			25a. DATE REC'D. BY REGISTRAR JUL 27 1983			25b. REGISTRAR'S SIGNATURE <i>J. H. Hawkins</i>							
BP																
DHMH - 16 50M 4/B2 (VRA 15, 4)																

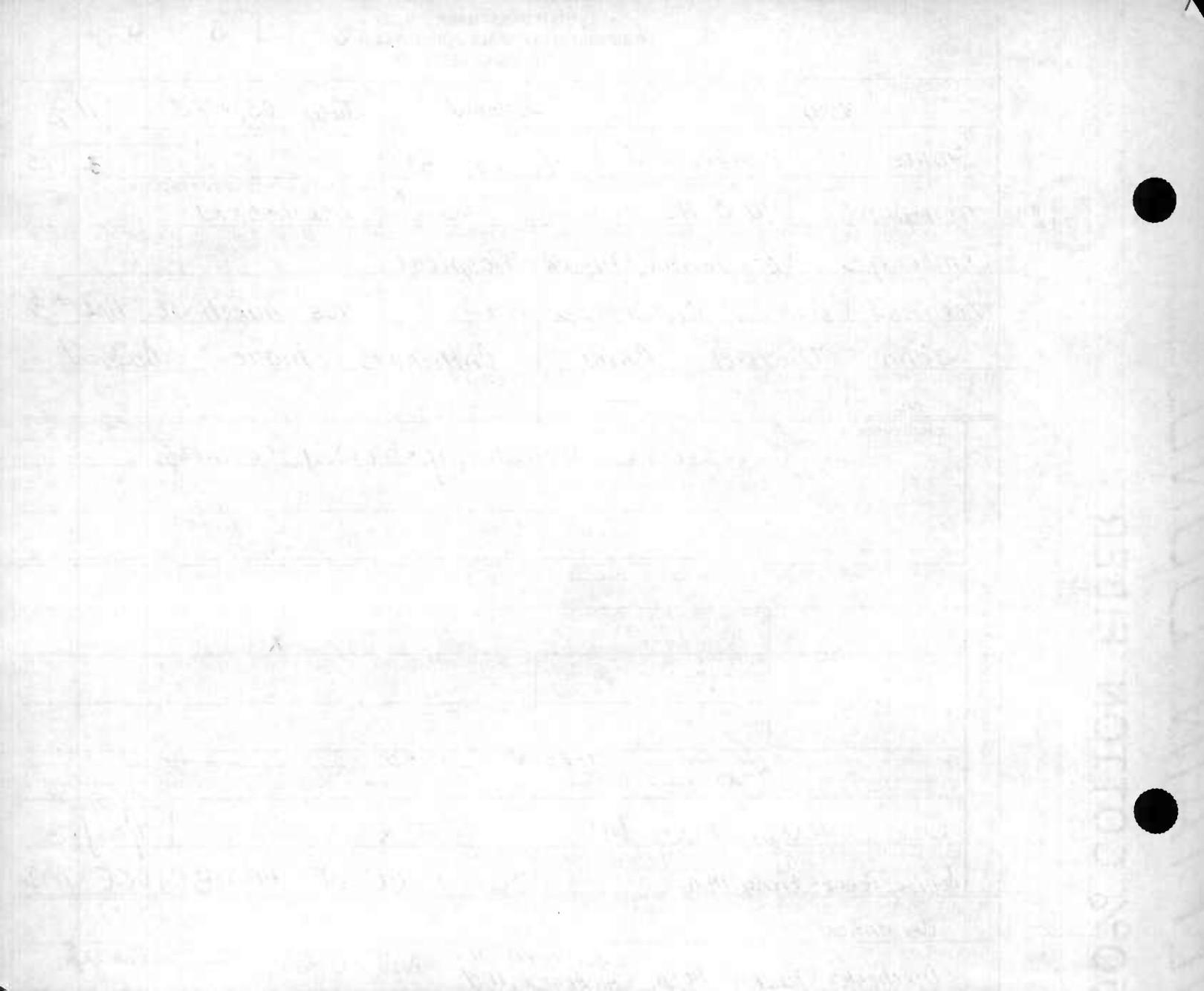


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 3 8 9 6 3						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
<i>Boy</i>									<i>Dodson</i>			<i>July 25, 1983</i>		<i>JULY</i>	<i>25</i>	<i>1983</i>	<i>11 10 AM</i>	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
<i>MALE</i>			<i>Caucasian</i>			MONTH <i>7</i> DAY <i>25</i> YEAR <i>83</i>			MONTHS <i>3</i> DAYS <i>15</i>			MONTHS <i>3</i>		HOURS <i>15</i> MIN. <i>15</i>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
<i>Maryland</i>			<i>U.S.A.</i>			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<i>Dorchester</i>									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
<i>Cambridge</i>			<i>Dorchester General Hospital</i>															
13a. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21613						
<i>Maryland</i>			<i>Dor.</i>			<i>Cambridge</i>			<i>705 Church St. Apt #3</i>									
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME															
FIRST <i>John</i>			MIDDLE <i>Michael</i>			LAST <i>Bain</i>			FIRST <i>Catherine</i>			MIDDLE <i>Marie</i>		LAST <i>Dodson</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
<i>NO</i>			—															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>severe prematurity ~24 week gestation</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
7650 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____												
22a. I certify that (I) (this hospital) attended the deceased from <i>7-25-83</i> , 19 <i>83</i> , to <i>7-25-83</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>7-25-83</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>Denise Perez-Fiercy MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>7/26/83</i>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Denise Perez-Fiercy, M.D.</i>			22e. ADDRESS <i>503 BURN ST CAMBRIDGE MD.</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>			23b. DATE <i>300 Byen St.</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Dorchester General Hosp. Cambridge, Md.</i>			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____									
24. FUNERAL DIRECTOR NAME <i>John J. Curran</i>			ADDRESS <i>300 Byen St.</i>			25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE <i>AUG 5 1983</i>												



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 18964			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR 100 AM			
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST						
KURT S GERBIG							9 ERB 19.						
3. SEX Male			4. RACE Cauca.		5. DATE OF BIRTH MONTH 6 DAY 5 YEAR 18			6. AGE (IN YEARS LAST BIRTHDAY) YRS. 65			IF UNDER 1 YEAR MONTHS — DAYS — IF UNDER 24 HRS. HOURS — MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany			7b. CITIZEN OF WHAT COUNTRY? yes			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.				
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tool Maker			12b. KIND OF BUSINESS OR INDUSTRY Caldwell Casting				
13a. STATE Md.			13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 104 Lee Drive		
14. FATHER'S NAME FIRST GUSTAV			MIDDLE		LAST GERBIG			15. MOTHER'S MAIDEN NAME FIRST ERNESTINE			MIDDLE LAST Gerdesingann		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) UNKNOWN			16b. SOCIAL SECURITY NO. 213-38-8387			17. INFORMANT MRS. GERBIG			ADDRESS 104 Lee Drive Camb. Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 At cut & degenerated abdomen										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Today			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19_____, to 19_____, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
27b. SIGNATURE <i>C. A. Davis</i>										DEGREE		22c. DATE SIGNED	
										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
27d. PHYSICIAN'S NAME (TYPE OR PRINT) M. S. SARAFI, M.D.			22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE 6/6/1983			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes		COUNTY SUSSEX STATE DELAWARE		
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD 21613							25a. PLAQUE READ BY REGISTRAR SUNG JUN 9 1983 <i>J. S. Gerdesingann</i>			
(VRA 15, 4)													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 1 8 9 6 5				
												REG. NO.				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			7 27 83		M		
Charles									Green JR.							
3. SEX MALE			4. RACE NEGRO			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 83			IF UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS. HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.							
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION CAMBRIDGE HOUSE NURSE. HOME			12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE LABORER			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MD.			13b. COUNTY DOR.			13c. CITY OR TOWN CAMBRIDGE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 930 PINE ST. CAMB., MD. 21613				
14. FATHER'S NAME FIRST CHARLES MIDDLE - LAST GREEN SR.						15. MOTHER'S MAIDEN NAME UNKWON										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 251-28-5724			17. INFORMANT (GRAND)MOTHER SHIRLEY HOWARD										
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																
DOUE TO, OR AS A CONSEQUENCE OF (b) <u>Degenerative heart disease</u>																
{ DOUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>old cerebral vascular accident i giddiness. old arter syphl mycoardial infarction</u>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>7-7-83</u> to <u>7-27-83</u> , that (I) (we) last saw the deceased alive on <u>7-9-83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																
22b. SIGNATURE <u>Edwin Fossett</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-27-83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Edwin Fossett</u>			22e. ADDRESS PO-Box 516 Cambridge Md. 21613													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-1-1983			23c. NAME OF CEMETERY OR CREMATORIAL Bethel AME Cem			23d. LOCATION CITY OR TOWN Cambridge			COUNTY Dor.		STATE Md.		
24. FUNERAL DIRECTOR NAME Lewis H. Boardley			ADDRESS 812 Hubbard St. A.B.			25a. DATE REC'D. BY REGISTRAR AUG 5 1983			25b. REGISTRAR'S SIGNATURE John L. Cooley							



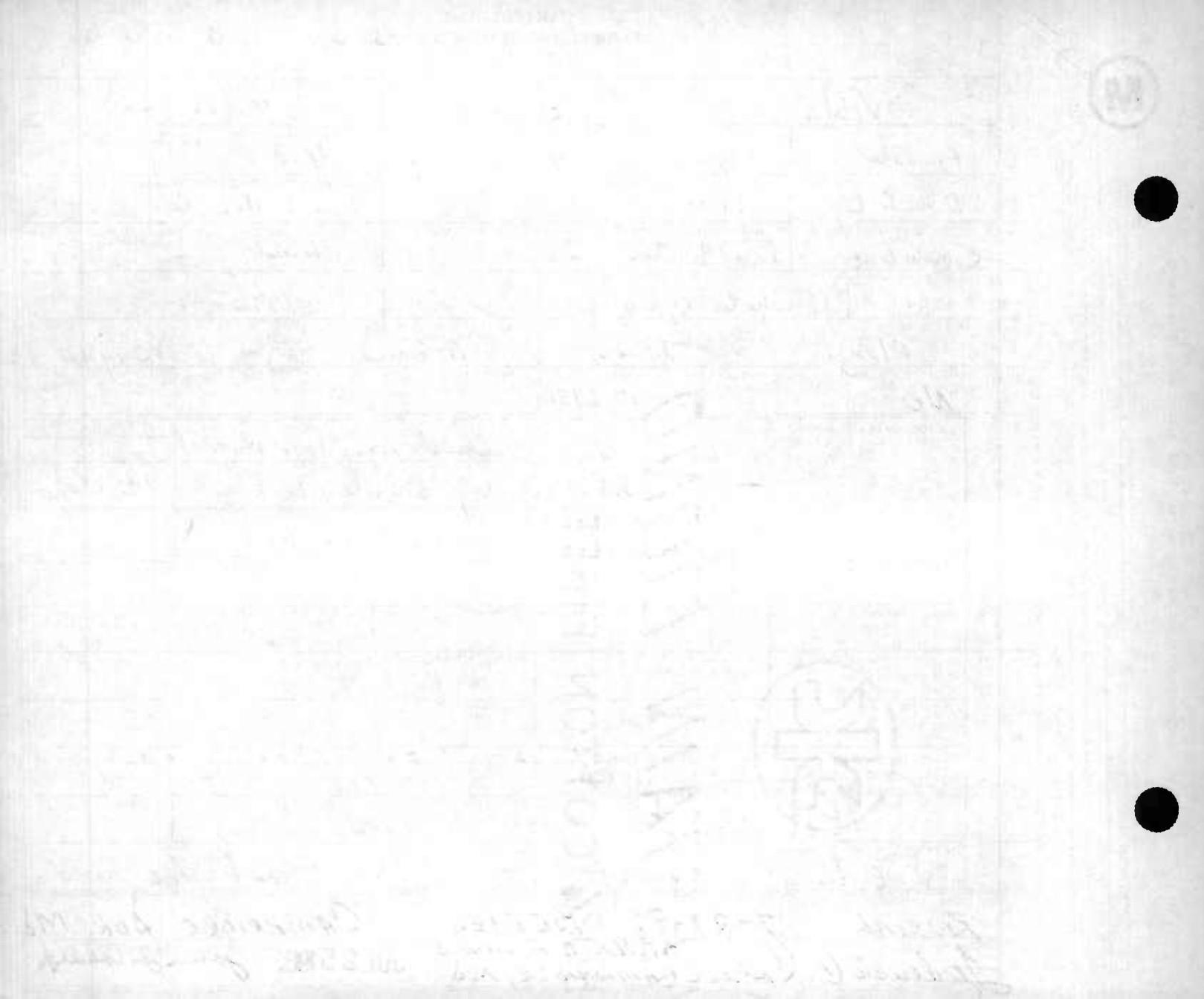
geo & coll

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 18966	
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR 7-22-83							2b HOUR	
1 DECEASED NAME FIRST (TYPE OR PRINT) <i>Violta</i>			MIDDLE		LAST <i>James</i>						
3. SEX Female			4 RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 9 8 09			6. AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dorch Co			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Donchester		10. KIND OF BUSINESS OR INDUSTRY MD	
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) Dorchester General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST WORKING LIFE) retired			12b. STREET ADDRESS 731 Park St 21613			
13a. STATE Md			13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Alonzo James</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Maurice Begayn</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-10-6481		17. INFORMANT			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>LARGE Right Cerebral infarct & Post</i> <i>4349</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Cerebral infarct & smaller left cerebellum infarct</i> <i>Hypertensive arteriosclerotic EVD.</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 7-12-1983 to 7-22-1983, that (I) (we) last saw the deceased alive on 7-22-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) see the body after death.											22c. DATE SIGNED
22b. SIGNATURE <i>J. Edwin Fossett</i>			22d. DEGREE <i>MD</i>		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Edwin Fossett</i>			22g. ADDRESS <i>P.O. Box 576 Cambridge, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (IF ANY) <i>BURIAL</i>			23b. DATE <i>7-27-83</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>BETHEL</i>			23d. LOCATION CITY OR TOWN <i>CAMBRIDGE S.D. MD.</i>		23e. COUNTY <i>SUSQUEHANNA</i>	
24. FUNERAL DIRECTOR <i>Fredrick C. Salair</i>			24a. ADDRESS <i>ST. CLAIR L. HOME CAMBRIDGE, MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 25 1983</i>			25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>			

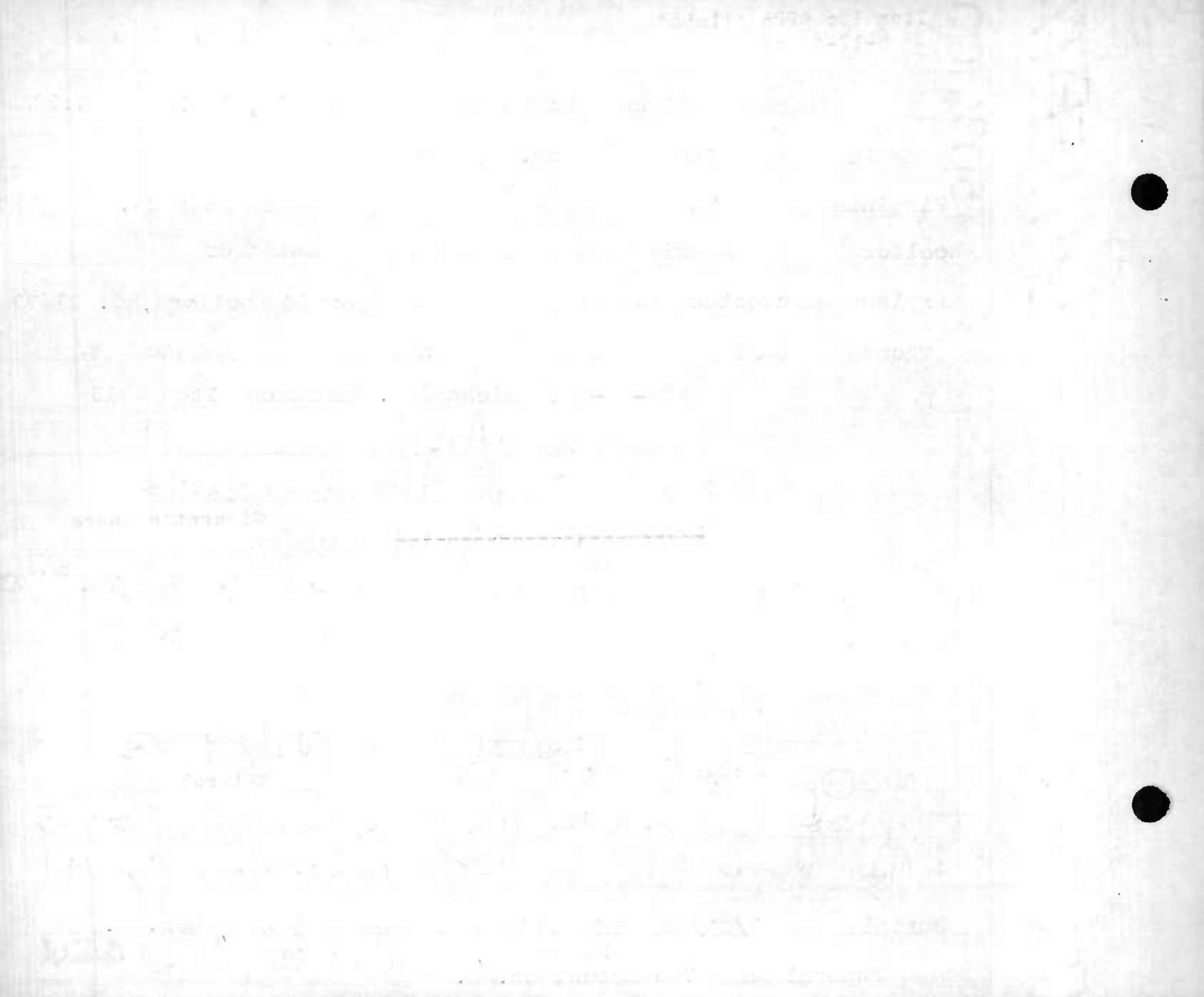


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR				
Mildred Wilson Lawrence						July 19, 1983				7:30PM				
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 72 HRS				
Female		White		Oct. 30, 1900		82		MONTHS		DAYS				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Virginia		US								Dorchester Co. MD.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Woolford			Laurie Lane (At Home)						Homemaker					
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS					
Maryland			Dorchester		Woolford				Box 54 Woolford, Md. 21677					
14 FATHER'S NAME FIRST			MIDDLE		LAST		15 MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Thomas			Burt		Wilson		Nancy				Wagoner			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		16c INFORMANT		17 ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			214-40-7178		Richard W. Lawrence		Item # 13							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Respiratory Arrest											
4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO OR AS A CONSEQUENCE OF Severe Chronic obstructive Airways dz (b) DUE TO OR AS A CONSEQUENCE OF Cigarette Usage (c) Exacerbation; Smoking											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)			Congestive Heart Failure						Died 8:25 PM 7/19/83					
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) this health care attended the deceased from <u>Feb 21, 1983</u> to <u>July 19, 1983</u> , that (I) (we) last saw the deceased alive on <u>July 19, 1983</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) view the body after death.														
22b. SIGNATURE			DEGREE						22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						1983					
H. Neal Reynolds			22e ADDRESS						408 Byrn St. Cambridge Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial			7/22/83		Old Trinity Church		Woolford		Dor. Md.					
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			REGISTRAR'S SIGNATURE		
Thomas Funeral Home			700 Locust St. Md.						JUL 26 1983			John J. Conigli		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												18968	
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2b. HOUR							
Donald Gary Lewis						July 10, 1983			45 PM				
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male			White		December 11, 1943		39						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.						
10. CITY OR TOWN OF DEATH Secretary			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 143 Main Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Interior Designer			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD			13b. COUNTY Dorchester		13c. CITY OR TOWN Secretary		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 143 Main Street 21664			
14. FATHER'S NAME FIRST Leo MIDDLE H. LAST Lewis					15. MOTHER'S MAIDEN NAME Marjorie					LAST Dann			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 055-36-4945		17. INFORMANT Marjorie Van Dine Secretary, MD			ADDRESS 143 Main Street			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Day		
<p>18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Uremia</u> <u>2503</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Diabetic Nephropathy</u> (c) <u>Diabetic mellitus</u></p> <p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Renal failure - Ascites</u></p>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) this hospital attended the deceased from <u>2/7 1983</u> , to <u>2/10 1983</u> , that (we) lost saw the deceased alive on <u>9/8 1983</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. I declare under oath that I did not view the body after death.													
22b. SIGNATURE <u>Donald T. Lewers, M.D.</u>						DEGREE			22c. DATE SIGNED 7/11/83				
22d. THIS CERTIFICATE'S NAME (TYPE OR PRINT) Donald T. Lewers, M.D.						22e. ADDRESS Rt 3 Box 106 Easton, MD 21601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 7-10-83			23c. NAME OF CEMETERY OR CREMATORIAL Park Cemetery			23d. LOCATION CITY OR TOWN Canton				
24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD						25a. DATE REC'D. BY REGISTRAR JUL 29 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Canfield</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If item 21 is marked or blank, it follows any injury, or other traumatic event, the infant was born prematurely.

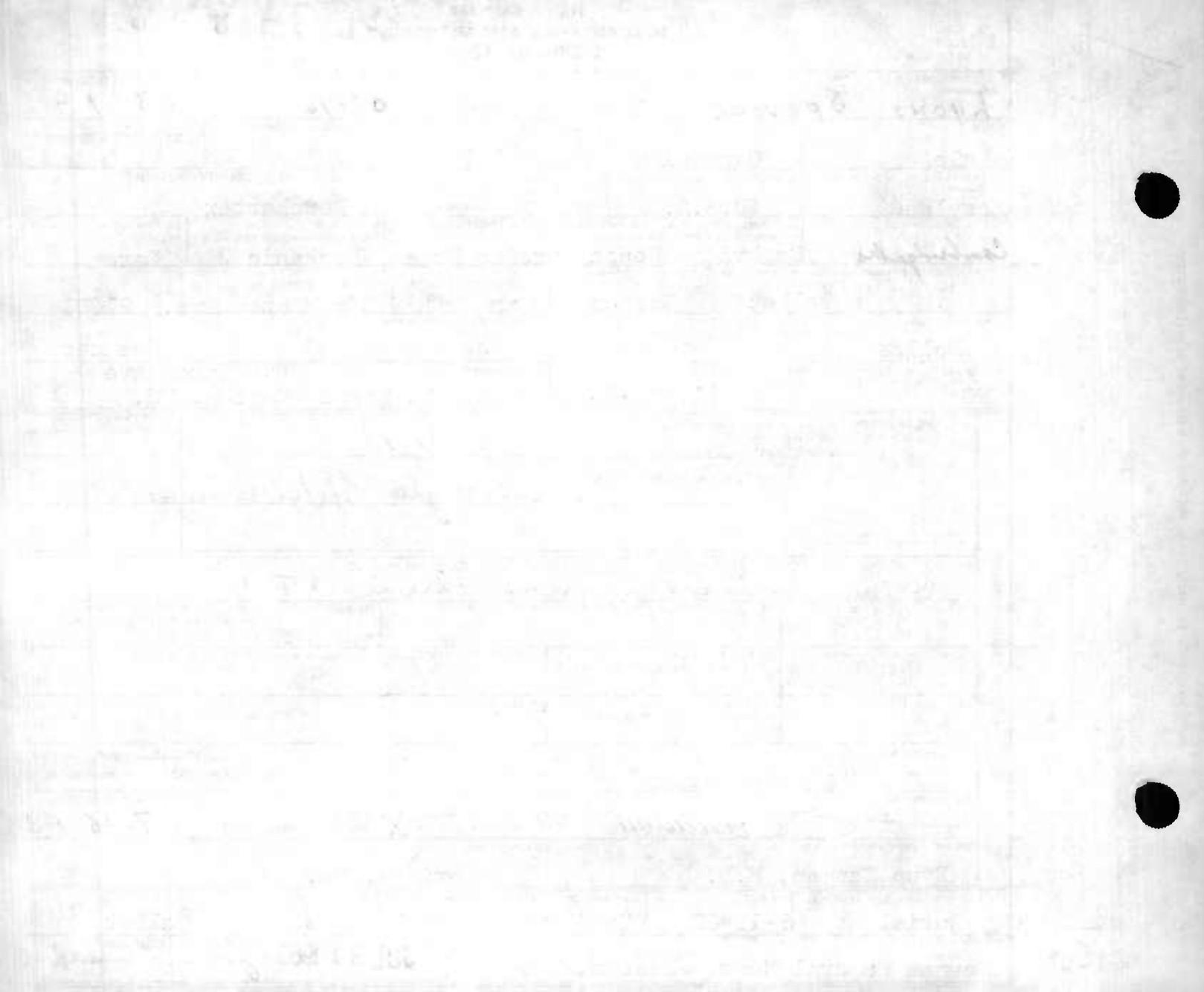
MEDICAL CERTIFICATION

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 | 8 9 6 9

1 DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
LYONS Spencer Nelson Lyons				07-16-		83		1A M
3. SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		7. HOUR
Male	Caucasian	NOV 25 1912		70	YRS	MONTHS	DAYS	IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.			WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Dorchester MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
Cambridge, Md.	Cambridge House Nursing Home				Mechanic			Farm
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.	Talbot	Easton	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		306 Winton Ave. 21601			
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST		
Dallas		Lyons	Ada			Spencer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO	217-30-7592		Janice M. Lyons		306 Winton Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)								
+360 CVA								
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Organic Brain Syndrome, chronic JT 1								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Spencer Newnam</i>		DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7-16-83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eyup Tanman, M.D.				22e. ADDRESS Cambridge, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 7-19-83	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Memorial		23d. LOCATION CITY OR TOWN Easton		COUNTY Talbot	STATE Md.	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home	ADDRESS Easton, Md.	25a. DATE REC'D BY REGISTRAR JUL 21 1983		25b. REGISTRAR'S SIGNATURE <i>John G. Schmid</i>				

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS IN 3, RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 8 9 7 0									
1- STATE REGISTRAR		1. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH 7- 30- 83	DAY 19	YEAR 83	2b. HOUR ?								
		Sam Ray Magee						<input checked="" type="checkbox"/>													
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH 7- 30- 83		DAY 19	YEAR 83	2d. HOUR 7AM					
Male		White		AUG. 22, 1925		57 yrs.															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester									
Louisiana		U.S.A.						<input checked="" type="checkbox"/>		<input type="checkbox"/>											
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 305 Somerset Ave.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver						12b. KIND OF BUSINESS OR INDUSTRY B-GREEN CO.							
Md.		11c. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 928. S. Curley St.		21224											
14. FATHER'S NAME SAM		MIDDLE LAST		15. MOTHER'S MAIDEN NAME MARTHA		16. SOCIAL SECURITY NO. 438-26-6219		17. INFORMANT George Hurlock		Somerset Ave. Cambridge, Md. 21613											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. ADDRESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Min.													
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion																					
4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF									
(b)												DUE TO, OR AS A CONSEQUENCE OF									
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE		John Mace Jr.										TITLE (SPECIFY) M.D.		Deputy				MEDICAL EXAMINER		DATE SIGNED 7/30/83	
EXAMINER'S NAME (TYPE OR PRINT)		John Mace Jr.										ADDRESS		Cambridge, Md. 21613							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 8-3-83			23c. NAME OF CEMETERY OR CREMATORIAL SAC HEART OF JESUS			23d. LOCATION CITY OR TOWN												
BURIAL																					
24. FUNERAL DIRECTOR NAME		THOMAS J. SKARDA										ADDRESS 2829 HUDSON ST.		25a. DATE REC'D. BY REGISTRAR AUG 1 1983		25b. REGISTRAR'S SIGNATURE John & Carol					
DHHM-17 (VR A15 ME(5)) 15M 7/77																					

2000	2000	2000	2000
2000	2000	2000	2000
2000	2000	2000	2000
2000	2000	2000	2000
2000	2000	2000	2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 1 8 9 7 1					
												REG. NO.					
1. FOR STATE REGISTRAR	2a. DATE OF DEATH MONTH DAY YEAR											2b. HOUR					
I. DECEASED NAME (TYPE OR PRINT)	FIRST RUSSELL			MIDDLE A.	LAST MAYER			7-22-83				11 PM					
3. SEX	4. RACE			5. DATE OF BIRTH MONTH 9 DAY 6 YEAR 05			6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.										
10. CITY OR TOWN OF DEATH 163 Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GEN. HOSP			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REPAIRMAN T.V. Repairman				12b. KIND OF BUSINESS OR INDUSTRY TELEVISIONS KODUCK									
13a. STATE 35 Md.	14b. COUNTY DORCH.			13c. CITY OR TOWN CAMBRIDGE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS Rd. Box 309 21613						
14. FATHER'S NAME FIRST Anton	MIDDLE	LAST Mayer			15. MOTHER'S MAIDEN NAME FIRST ANNA				MIDDLE	Daffin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. WW II			17. INFORMANT step-daughter				ADDRESS Linkwood, Md. 21835									
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Obstruction to (R) upper/middle/lower Bronch Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b 19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (we) attended the deceased from saw the deceased alive on 7/14/83 19... to 7/22/83 ... that (I) (we) last saw the deceased alive on 7/22/83 19... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.																	
22b. SIGNATURE T. Russell		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 7/25/83											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 7/27/83		23c. NAME OF CEMETERY OR CREMATORIAL Eastern Md. Vet's Cem., Shore		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
24. FUNERAL DIRECTOR NAME CURRAN FUNERAL HOME,		ADDRESS 308 High St., Cambridge, Md. 21613		25a. DATE REC'D. BY REGISTRAR JUL 27 1983		25b. REGISTRAR'S SIGNATURE Sam & Curran											

12-10-25-001-01

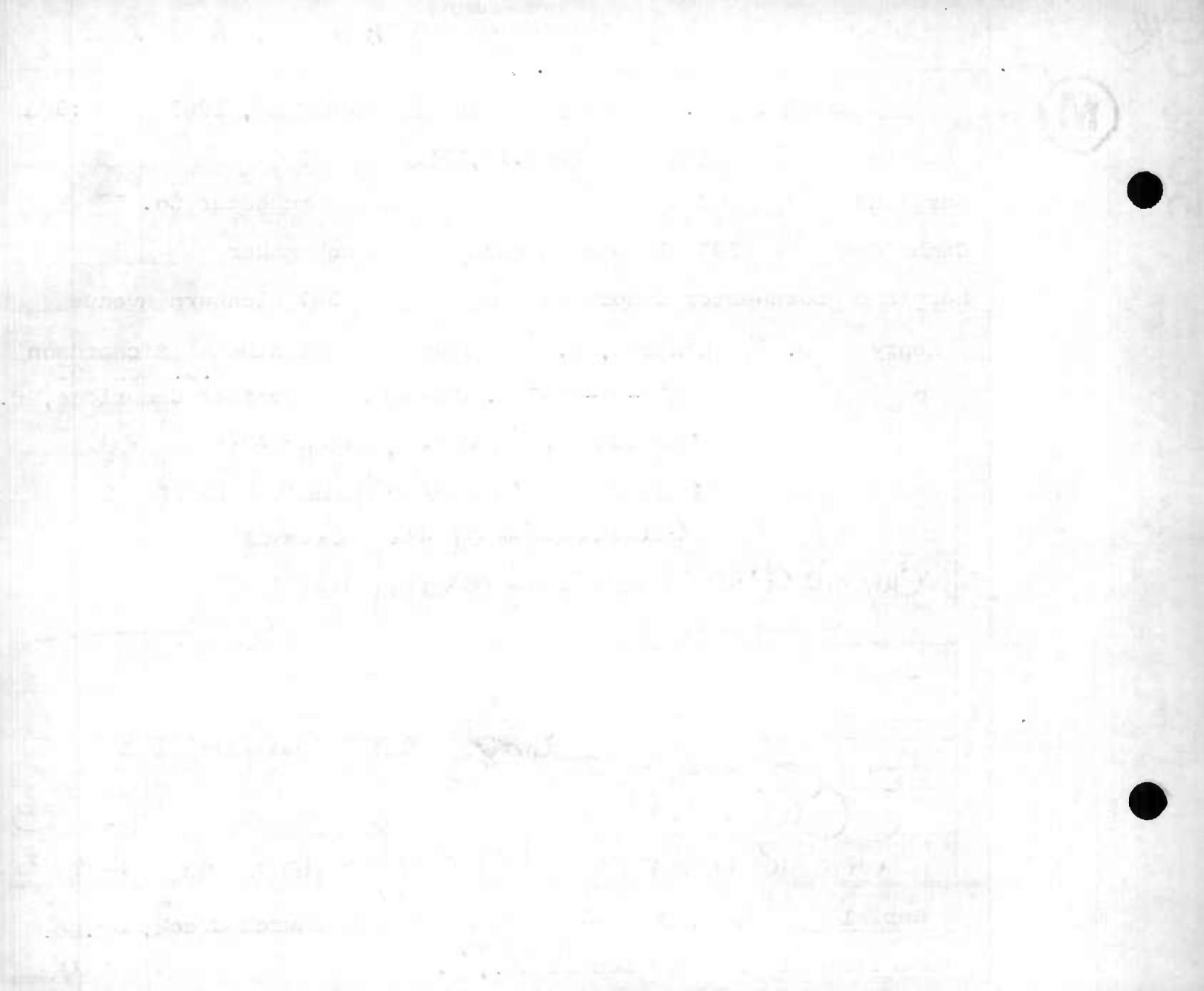
WILSONVILLE, OREGON

M

XO
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be dated for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										1 8 9 7 2			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Sarah E. Merryweather						July 24, 1983			9:30 AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Female		White		Sept. 15, 1919			63 YRS			IF UNDER 24 HRS MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD			
Maryland		US					Dorchester Co.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Cambridge		307 Glenburn Avenue								Homemaker			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Maryland		Dorchester		Cambridge						307 Glenburn Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Henry D. Linthicum, Sr.		Mary Elizabeth Richardson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
No		219-07-7333		P.O. Box 253 E. Thomas Merryweather Cambridge, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Respiratory failure, hepoxia 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										3 da			
(b) malignant pleural effusion, fibrosis (c) carcinoma of the lung													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Carcine obstructive pulmonary disease													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
29										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____									
22a. I certify that (I) (this hospital) attended the deceased from <u>July 22, 1983</u> to <u>July 24, 1983</u> , that (I) (we) last saw the deceased alive on <u>July 22, 1983</u> , and that if (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I)(we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE								22c. DATE SIGNED			
Ann R. Wilce										7-25-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22e. ADDRESS			
Ann R. Wilce										400 Maryland Ave 21613			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL 80 Trinity Churchyard			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE			
Burial		7/26/83					Church Creek, Dor. Md.						
24. FUNERAL DIRECTOR NAME		ADDRESS								25a. DATE REC'D. BY REGISTRAR			
Thomas Funeral Home		Cambridge, 700 Locust St., Md.								25b. REGISTRAR'S SIGNATURE			
										AUG 04 1983 John J. Conroy			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

item 5&6 #G582 8/18/83 ph

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 1 8 9 7 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Henry		Moore	7-22-83				5 p.m.	
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male			Negro	MONTH	DAY	YEAR	82	90	YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Va.			USA						Dorchester MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge			Cambridge House Nursing Home			Laborer			Farm		
13a. STATE Md.			13b. COUNTY Worcester			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 2 Bx. 11621861		
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			LAST			
Henry				Moore, Sr.	India			Scarborough			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			WWI			218-14-1273 Annie L. Moore			Rt. 2 Bx. 11621861 Pocomoke, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. CONDITIONS FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1629											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.			21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
(b)			caused - Pulmonary Arrest								
(c)			ca of lung w/ brain metastasis								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>G. Lannigan</i>		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED JUL 25 1983				
22e. PHYSICIAN'S NAME (TYPE OR PRINT)				22f. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 7-30-83		23c. NAME OF CEMETERY OR CREMATORIAL Georgetown Cem.			23d. LOCATION CITY OR TOWN Pocomoke		COUNTY War.	STATE Md.	
24. FUNERAL DIRECTOR <i>Samuel S. New Church, Va.</i>		ADDRESS					25a. DATE REC'D. BY REGISTRAR JUL 25 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Carroll</i>		

M

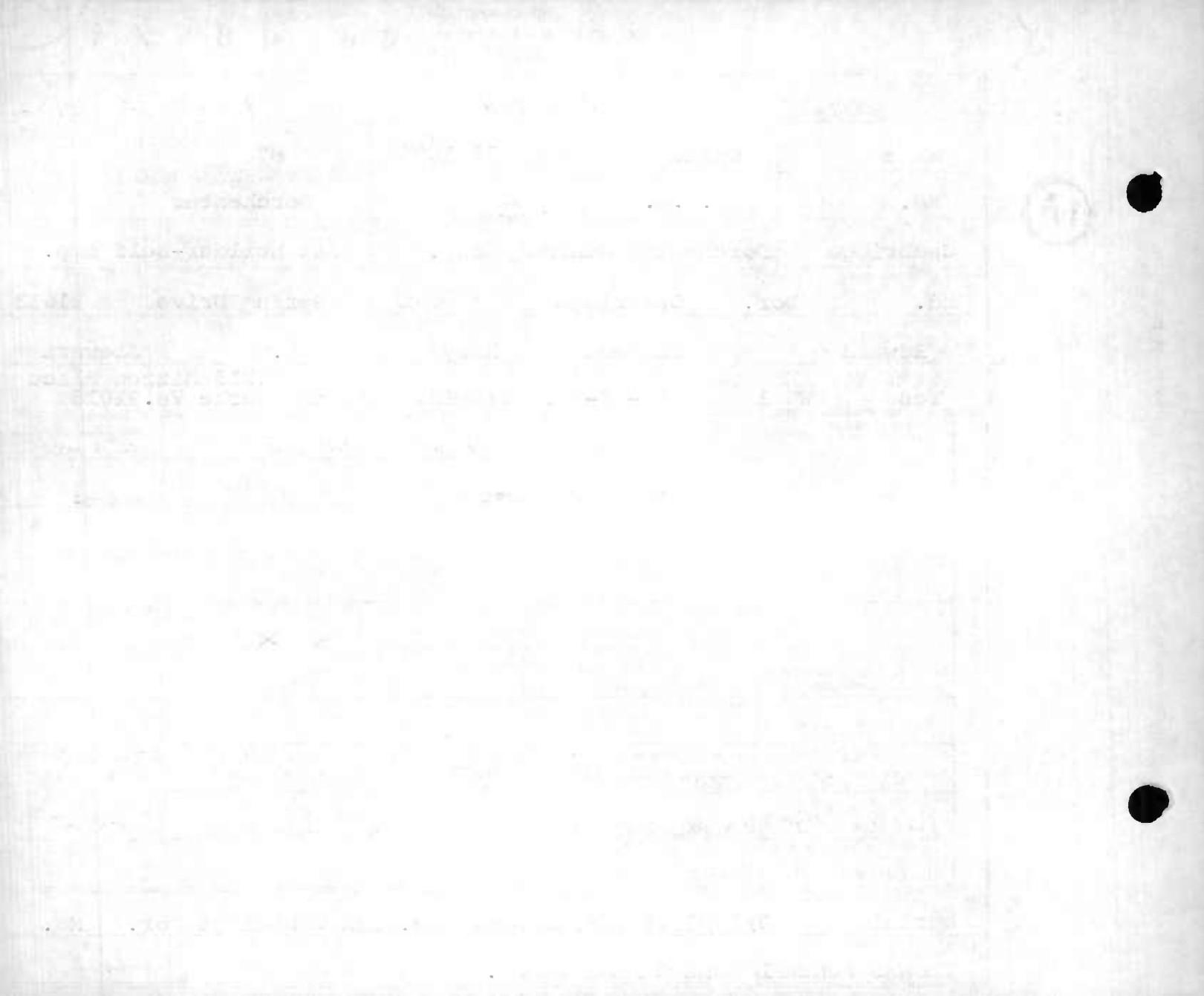


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign here.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, please completely fill in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma or event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 18974								
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR 7 - 28 - 83									2b HOUR 7:40 AM								
1 DECEASED NAME (TYPE OR PRINT) ROBERT			MIDDLE PEARSON			5. DATE OF BIRTH MONTH DAY YEAR May 31 1896			6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN								
3. SEX male			4. RACE white			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester								
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.									12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) boat builder-self emp.			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.			13b. COUNTY Dor.			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Spring Drive			21613					
14. FATHER'S NAME FIRST MIDDLE LAST Edward Pearson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary W. Stewart																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW 1			17. INFORMANT ADDRESS 7315 Mizzen Place Virginia Miller Burke Va. 22015														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 days								
(c) DUE TO, OR AS A CONSEQUENCE OF												4608								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from 7/13 1983 to 7/28 1983, that (1) (we) lost saw the deceased alive on 7/27 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.																				
22b. SIGNATURE Michael A. Mosiewicz MD															22c. DEGREE					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSIEWICZ MD															ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 7/30/1983			23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park Cambridge Dor.			23d. LOCATION CITY OR TOWN Cambridge Dor.			STATE Md.								
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE MD.															25a. DATE REC'D. BY REGISTRAR AUG - 9 1983			25b. REGISTRAR'S SIGNATURE John J. Cahill		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												1 8 9 7 5
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR M
Anthony Vincent Peterson						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7	16	1983	8 PM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR M
M	White	12 21 66	16			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7	16	1983	10 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
MD		USA						Dorchester County MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge		Dorchester General			Student			-				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
MD	Dorchester	Hurlock				Waddell's Corner 21643						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Billy Arthur Peterson			Dahoia Bonella									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			217-96-1193			Billy A. Peterson			Rt. 2, Box 25B Hurlock, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Drowning, salt water</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <u>(ACCIDENTAL)</u> BETWEEN ONSET AND DEATH												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
									YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> INJURY CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 8 P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
						Accidental drowning - no Injury						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, STORE, FARM, ETC.) N/A			21f. LOCATION STREET Hunting Creek Bridge Choptank, Md			CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion						
ACTUAL SIGNATURE <i>Donald R. McWilliams, M.D.</i>			TITLE (SPECIFY) <i>ASSIST.</i>			MEDICAL EXAMINER			DATE SIGNED <u>7-18-83</u>			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS <u>308 Gray St. Cambridge, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 7-19-83			23c. LOCATION Eastern Cemetery Veterans Cemetery			23d. LOCATION Bel Air CITY OR TOWN Dorchester COUNTY MD STATE			
24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD			25a. DATE REC'D. BY REGISTRAR JUL 25 1983			25b. REGISTRAR'S SIGNATURE <i>Jean S. Smith</i>						

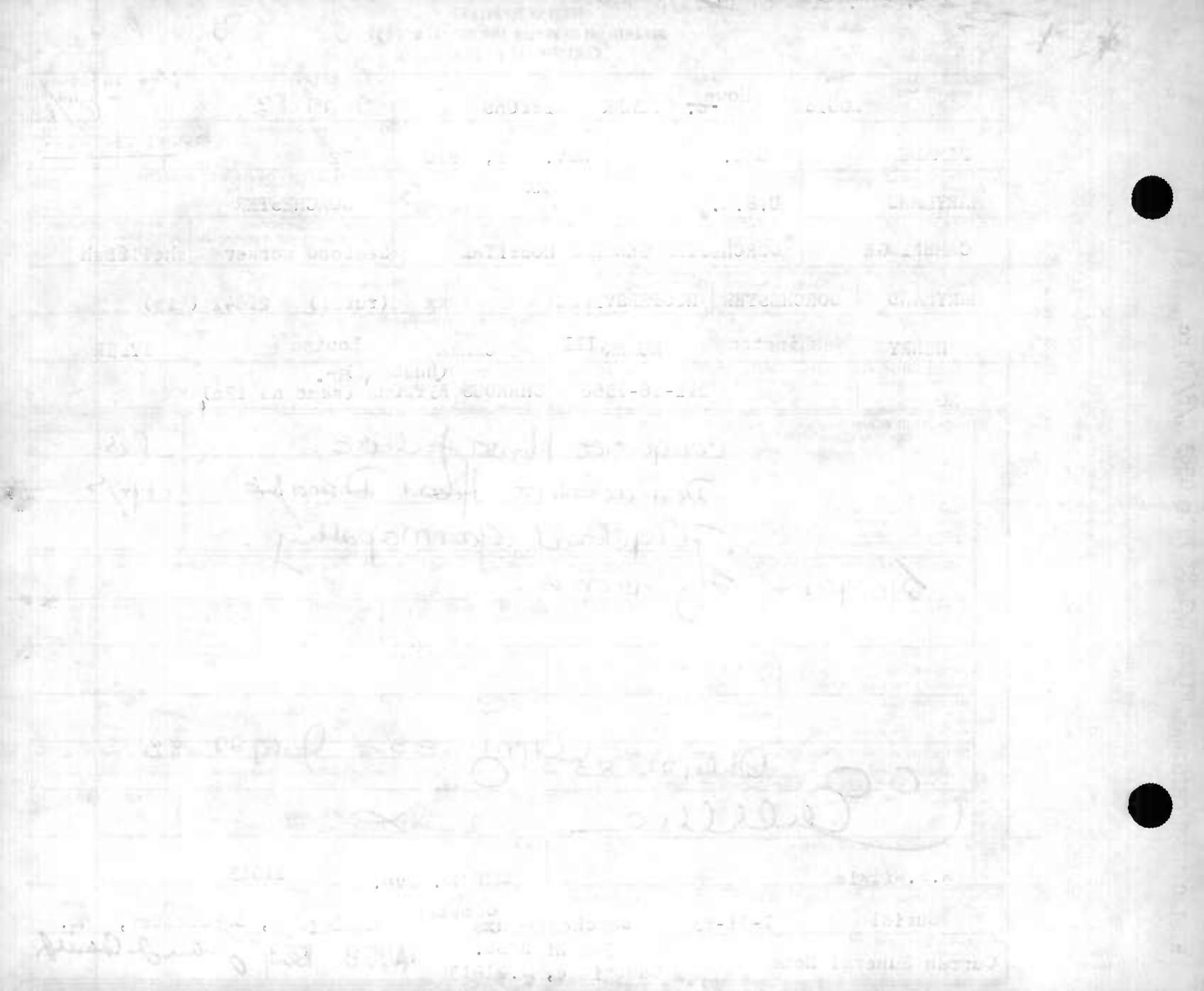
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 8976			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
LOUISE HOWE B. RUARK RIPPONS						7.27.83.						6:49 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		CAU.		MONTH NOV. DAY 9, 1910 YEAR			72 YRS.			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER								
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seafood worker			12b. KIND OF BUSINESS OR INDUSTRY shellfish					
13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN HOOPERSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS (rural) 21642 (zip)							
14. FATHER'S NAME FIRST HENRY		MIDDLE Washington		LAST RUARK III		15. MOTHER'S MAIDEN NAME FIRST CLARA		MIDDLE Louisa		LAST TYLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-16-1366		17. INFORMANT (husband) Sr. CHANDUS RIPPONS (same as 13e)		ADDRESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE Heart failure. 2731 DUE TO, OR AS A CONSEQUENCE OF (b) Degenerative Heart Disease. w/p Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Gorgie's syndrome -															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) July 20, 1983		21f. LOCATION STREET April 1983		CITY OR TOWN July 21 1983		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 20, 1983 , and that (I) (we) last saw the deceased alive on July 20, 1983 , and that is (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.															
22b. SIGNATURE A. R. Wilkie		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 21613								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) A. R. Wilkie		22f. ADDRESS 400 Md. Ave.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-31-83		23c. NAME OF CEMETERY OR CREMATORIAL Cemetery			23d. LOCATION CITY OR TOWN Cambridge			COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Curran Funeral Home		ADDRESS 308 High St. Cambridge, Md. 21613		25a. DATE REC'D. BY REGISTRAR AUG 8 1983			25b. REGISTRAR'S SIGNATURE John J. Curran								

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 18971					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
<i>Edith</i>			<i>F.</i>	<i>Seibert</i>				<i>7 4 83</i>					<i>1:10 PM</i>		
3. SEX			4 RACE		5 DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
female			white		MONTH 09 DAY 23 YEAR 1894			88		YEARS	MONTHS	DAYS	HOURS	MIN	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New Jersey</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i>							
10 CITY OR TOWN OF DEATH <i>Cambridge</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cambridge House</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>book keeper</i>			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <i>Md.</i>			13b. COUNTY <i>Dor.</i>		13c. CITY OR TOWN <i>Cambridge</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>520 Glenburn Ave.</i>					
14 FATHER'S NAME FIRST <i>John</i>			MIDDLE <i></i>	LAST <i>Hopper</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Alice</i>			MIDDLE <i></i>	LAST <i>Van Vorhees</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> no			16b. SOCIAL SECURITY NO <i>074-14-6807</i>			17. INFORMANT <i>Robert W. Seibert</i>			ADDRESS <i>Oxford Md. 21654</i>						
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY <i>4360</i> IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>CVA</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Arteriosclerosis</i>															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Urinary Tract infection, Poor general Condition</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____ to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Tanman</i>			22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>7-4-83</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. Tanman</i>			22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 7/5/83			23c. NAME OF CEMETERY OR CREMATORIAL DELMARVA CREM.			23d. LOCATION CITY OR TOWN LEWES		COUNTY SUSSEX	STATE DEL.			
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR JUL 12 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Church</i>						

BP

DHMH-16 25M
(VRA 15, 4) 1/79

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGES 5 THROUGH 10. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH18978
REG. NO.

1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED												2b. HOUR					
			<input checked="" type="checkbox"/> 7-6 19 83												P M					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
Eldridge D. Sharp												July 6, 1983			6:54 PM					
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2e. DATE PRONOUNCED DEAD						
Male Negro		3-12-1910		73 yrs.			MONTHS		DAYS		HOURS		July 6, 1983							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Md.		USA											Dorchester County MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge			DOA Dorchester General Hosp.												Ret. Laborer					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS									
Md.			Dor.		Cambridge						608 Douglas St. 21613									
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
Uriel						Sharp			Caroline						?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS											
No									Andrea V. Sharp			608 Douglas St.			Cambridge, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Mins.																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?					
															YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																				
ACTUAL SIGNATURE <i>John Mace Jr. M.D.</i> TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER																				
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D. ADDRESS Cambridge, Md.																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE					
Burial			7/9/83			Union Chapel			Cordtown			Dor.			Md.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
St. Clair Funeral Home Cambridge, Md.						JUL 13 1983			<i>John Mace Jr. M.D.</i>											
DHMH-17 (VR A15 ME(5)) 15M 7/77																				

W

поламізод вчепати

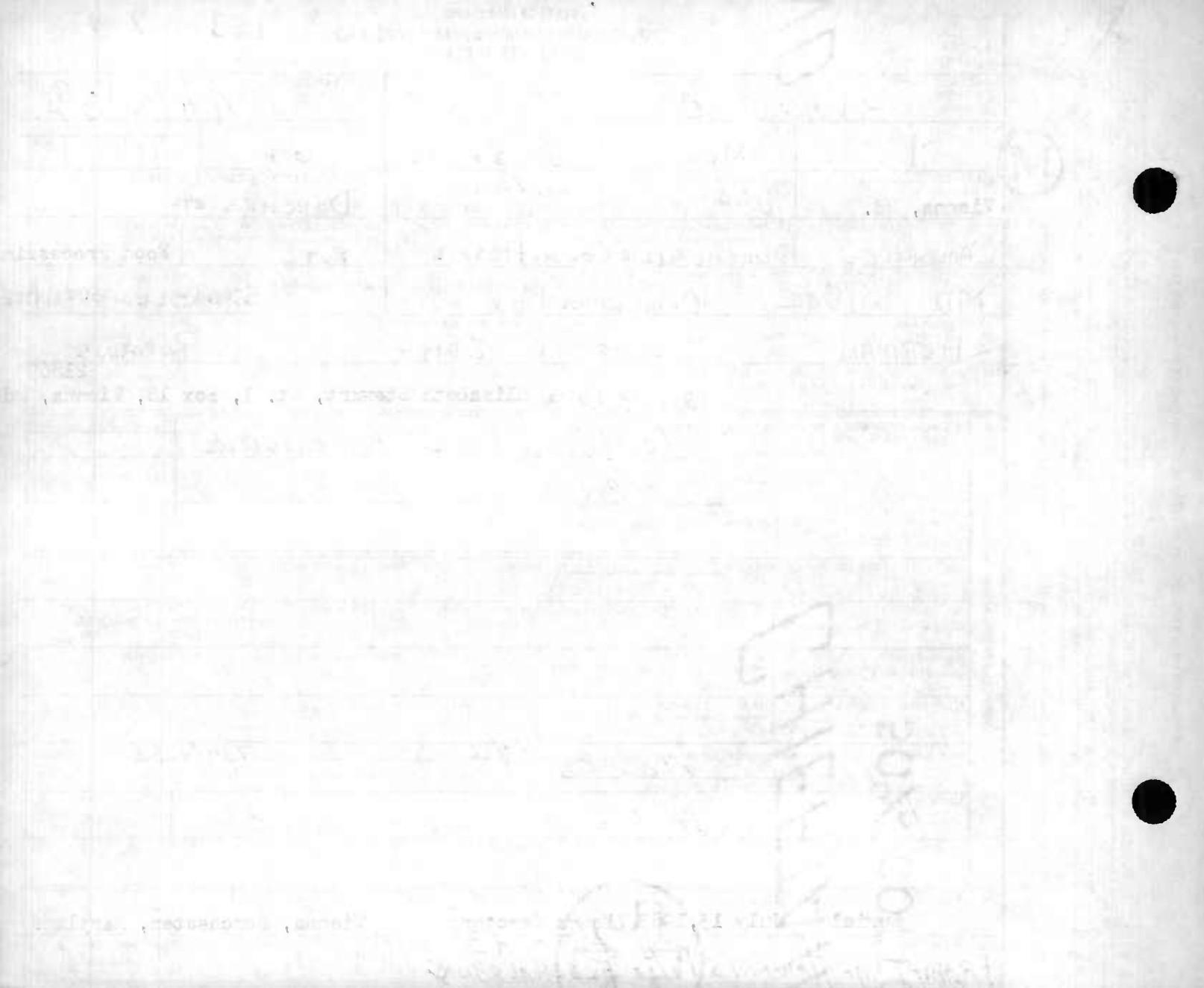
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 18979		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
MONROE C.					STEWART	7/11/83		7/11/83	3 A.M.	3 P.M.		
1. SEX		M	4. RACE		NEG	5. DATE OF BIRTH		MONTH	DAY	YEAR	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Vienna, Md.	7b. CITIZEN OF WHAT COUNTRY?		USA	8. MARRIED WIDOWED		<input checked="" type="checkbox"/> NEVER MARRIED	<input type="checkbox"/> DIVORCED	6. AGE IN YEARS (LAST BIRTHDAY) YRS.	69 YRS.	
10. CITY OR TOWN OF DEATH		CAMBRIDGE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		DORCHESTER GEN. HOSPTL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		DORCHESTER MD.			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		MD	13b. COUNTY		DOR	13c. CITY OR TOWN		CAMBRIDGE			Food Processing	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		21613 520 GLENBURN AVE								
14. FATHER'S NAME		FIRST HERMAN	MIDDLE	LAST STEWART	15. MOTHER'S MAIDEN NAME		FIRST EDITH	MIDDLE	LAST ROBBINS	ADDRESS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN?)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		17. INFORMANT		ADDRESS		21869		
? <input type="checkbox"/>		218-12-1358		Elizabeth Stewart, Rt. 1, Box 16, Vienna, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>@ Lower lobe Pneumonia</u>												
3109												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DOUE TO, OR AS A CONSEQUENCE OF (b) <u>Ops</u>												
{ DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>7/14 1983</u> to <u>7/14 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <u>Dr. members</u>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED		
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		July 15, 1983		Vienna Cemetery		Vienna, Dorchester		Maryland				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
FROMPTOM - HAWKINS F.I.		FEDERALSBURG		JUL 18 1983		John J. Carroll						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 3 3 1 8 9 8 0			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
ALTON M. Travers, Sr.						7 28 83			7	5	83				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
MALE			NEGRO			MONTH DAY YEAR			35 YRS			MONTHS	DAYS	IF UNDER 24 HRS	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Dorchester Co., Md.			USA						DORCHESTER						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
CAMBRIDGE MD			DORCHESTER General Hosp.			NONE									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
MD			Dorchester			Hamperville						General Delivery			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	ROSS			
OLIVER					Travers	Bernice						601 GREENWOOD AVE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			OLIVER TRAVERS CAMBRIDGE, MD			
YES VIETNAM															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:			18. IMMEDIATE CAUSE (a)			18. DUE TO, OR AS A CONSEQUENCE OF (b)			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
1629			meiastatic carcinoma			carcinoma right upper lobe of lung			5 months						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
18. DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN DETERMINING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>July 4</u> , 19 <u>83</u> , to <u>July 5</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>July 4</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>James E. Fassett</i>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED JULY 5, 1983						
22d. PHYSICIAN'S NAME (PRINT)			22e. ADDRESS PO - Box 576 Cambridge md.												
James E. Fassett MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 7-11-83			23c. NAME OF CEMETERY OR CREMATORIAL VETERANS			23d. LOCATION CITY OR TOWN BWI LAKE BOR. MD.						
Burial			7-11-83			VETERANS			BWI LAKE BOR. MD.						
24. FUNERAL DIRECTOR NAME Federick C. Allen			ADDRESS ST. CLAIR F. HOME CAMBRIDGE, MD.			25a. DATE REC'D. BY REGISTRAR JUL 13 1983			25b. REGISTRAR'S SIGNATURE John J. Conigliaro						

M

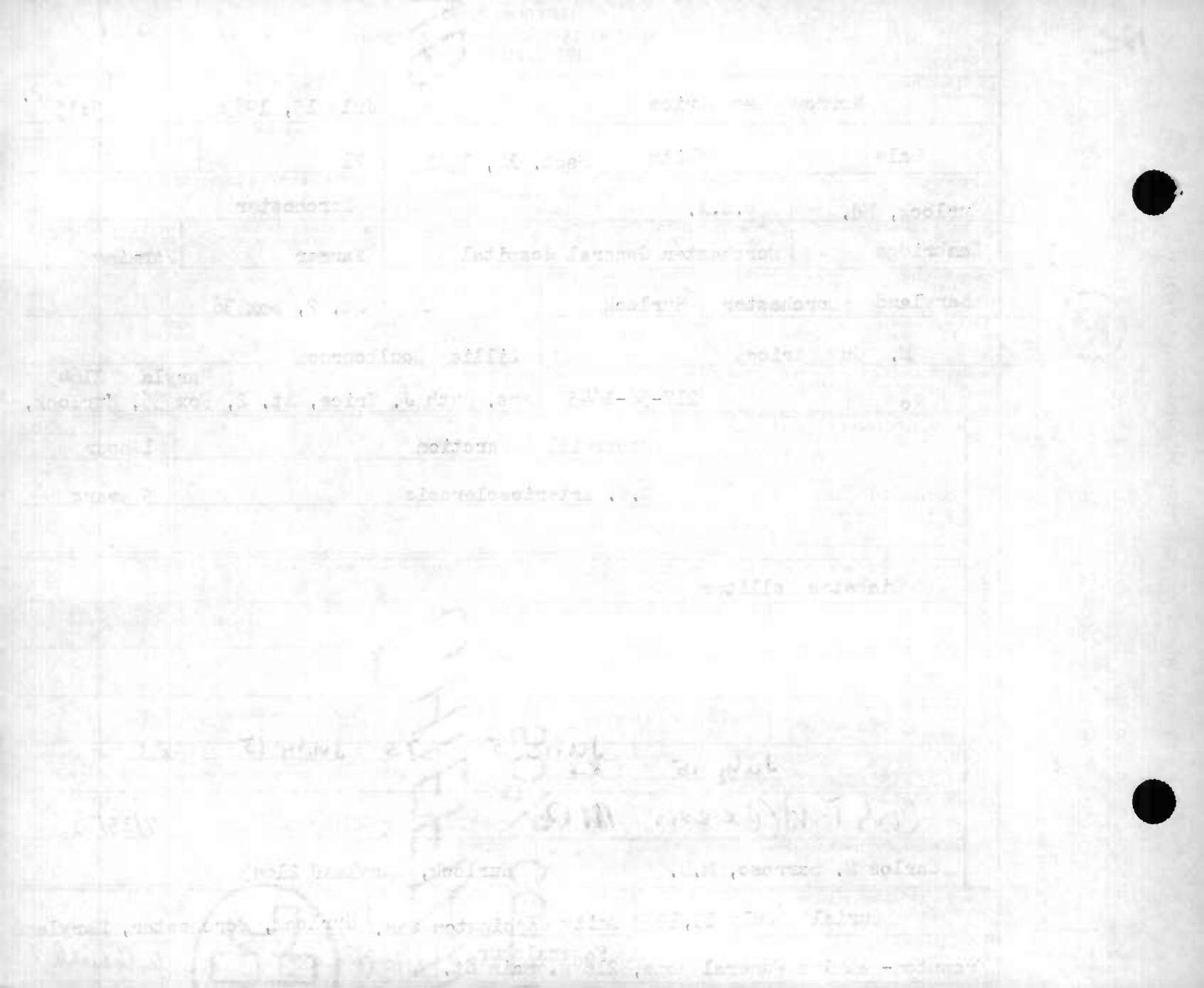
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 18981				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR P. 3:15 M				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			July 15, 1983								
Norman Lee Trice														
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male			White			Sept. 13, 1911			71 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Hurlock, Md.			U.S.A.						Dorchester					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge			Dorchester General Hospital			Farmer			Farming			21643		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Dorchester		Hurlock					Rt. 2, Box 36			21643	
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			ADDRESS					
M. Guy Trice						Lillie Coulbourne			Maryland 21643					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Mrs. Ruth J. Trice, Rt. 2, Box 36, Hurlock,			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			217-36-1645									1 hour		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction														
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DOUE TO, OR AS A CONSEQUENCE OF (b) C.V. arteriosclerosis														
DOUE TO, OR AS A CONSEQUENCE OF (c)														
5 years														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									<input type="checkbox"/> NO <input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from June 5, 1973, to July 15, 1983, that (I) (we) last saw the deceased alive on July 15, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Carlos F. Barroso, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/15/83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
Carlos F. Barroso, M.D.			Hurlock, Maryland 21643											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			July 19, 1983			Unity Washington Cem.			Hurlock, Dorchester, Maryland					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Frampton-Hawkins Funeral Home, 218 N. Main St.			Federalsburg			AUG 01 1983			John J. Conwell					



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 1 8 9 8 2		
												REG. NO.		
1 - FOR STATE REGISTRAR			I DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
ALFRED R. WALLACH									7/9/83			6 PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS AT BIRTHDAY) MONTHS YRS			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN				
M		W		11 14 94			88							
10. BIRTHPLACE COUNTRY		11. CITIZEN OF WHAT COUNTRY?		12. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			13. BALTIMORE CITY OR COUNTY OF DEATH			14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Baltimore, Md		U.S.					Baltimore Co., Md			WATERMAN				
16. CITY OR TOWN OF DEATH		17. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE, GIVE STREET ADDRESS)		18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			19. 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20. STREET ADDRESS				
CAMBRIDGE		EASTERN SHORE HOSPITAL CENTER		MARYLAND			NO			21624				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
PAUL WALLACH			MARTHA RITENHOUSE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <input checked="" type="checkbox"/> YES WW I			16b. SOCIAL SECURITY NO. 216-01-3793			17. INFORMANT MARGARET C. WALLACH			21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH CLATBORNE, Md. 21624					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 PULM EMBOLI & PALM INFARCT 5 months DUE TO, OR AS A CONSEQUENCE OF myocardial infarct & pneumonia			(b) A SCVD DUE TO, OR AS A CONSEQUENCE OF			(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7/9/83 to 7/9/83, that (I) (we) last saw the deceased alive on 7/9/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE George Beck MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Beck MD		22e. ADDRESS E.S.H.C. CAMBRIDGE, MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 12, 1983		23c. NAME OF CEMETERY OR CREMATORIAL WINDYHILL CEM		23d. LOCATION CITY OR TOWN EASTON		COUNTY		STATE TALBOT MARYLAND				
24. FUNERAL DIRECTOR NAME Harmon E. Leonard		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 18 1983		25b. REGISTRAR'S SIGNATURE John J. Conner								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial; cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										1 8 9 8 3			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
<i>Raymond</i>			<i>E.</i>	<i>Woodland</i>		<i>7 21 83</i>					<i>1 P M</i>		
3. SEX <i>M</i>			4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 22, 1896</i>		6. AGE (IN YEARS LAST BIRTHDAY) 87		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester Co. MD.</i>						
10. CITY OR TOWN OF DEATH <i>Cambridge, md.</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cambridge House</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Waterman</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>31229</i>						
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1244 Haver Hill Road</i>				
14. FATHER'S NAME FIRST <i>Charles</i>			MIDDLE <i>E.</i>	LAST <i>Woodland</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Julia</i>		MIDDLE <i>Meekins</i>	LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>218-05-8421</i>		17. INFORMANT <i>Samuel E. Woodland, Baltimore</i>		ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4292</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASCV2 c permanent pacemaker</i>													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Ca of Colon, old CVA, Bladder tumor</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Caraway</i>			22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>7-21-83</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John J. Caraway</i>			22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>7/24/83</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Dor. Memorial Park</i>		23d. LOCATION CITY OR TOWN <i>Cambridge, Dor. Md.</i>		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME <i>John J. Caraway</i>			ADDRESS <i>700 Locust St - Cambridge, Md 21613</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 26 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Caraway</i>						

